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Learning spiritual care in Dutch hospitals

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How spirituality is integrated system-wide in the Netherlands Palliative Care National Programme



Chapter 2. How spirituality is integrated system-wide in the Netherlands Palliative Care National Programme

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Abstract

After the decline of the compartmentalisation of Dutch society, where healthcare was being organized along confessional / denominational lines, spirituality became neglected or implicit for decades in The Netherlands healthcare system. During the modernisation of healthcare in the 1960s, the development of professional language concerning chaplaincy and psychosocial care in a secularising society created a blind spot for this fundamental dimension of care. From the moment palliative care in the Netherlands became part of a national programme, healthcare providers, policymakers and researchers were presented with the challenge of reassessing this complex concept. National policy and personal initiatives on research and education connected in an inspiring process that led to a Dutch, consensus-based national guideline for multidisciplinary spiritual care as part of palliative care, the adjustment of the professional standard of healthcare chaplaincy in the Netherlands and the initiative for a European Taskforce on Spiritual Care. In the appendices of this paper the first English-language summary of the Dutch guideline on spiritual care and the European Association for Palliative Care (EAPC) definition of spirituality are presented.

Keywords: Chaplaincy, Healthcare system, Multidisciplinary guideline, Palliative care, Spiritual care

Introduction

In Dutch healthcare organisations, ‘spirituality’ or ‘spiritual care’ were not frequently used concepts until recent palliative care developments (referring to the WHO definition of palliative care) reintroduced these words. The word ‘spirituality’ (NL: *spiritualiteit*) is a familiar word in Dutch language in some Christian traditions, and the concept is used in contemporary esoteric and new age publications. It has never been used, however, to refer to the practice of healthcare chaplains, nor to the spiritual dimension of nursing or medicine. It was only after 2001 – the year in which the Dutch government placed the integration of modern hospice and palliative care on the agenda of regular healthcare organisations⁽¹⁾ that healthcare providers and administrators were confronted with spirituality as a concept. Its prominent place in the WHO definition of palliative care challenged healthcare chaplains and researchers to explain how this rather vague concept, which is often used outside of the context of healthcare, related to the developments in the Dutch healthcare system.

In this paper we will describe how spiritual care was incorporated into the Dutch healthcare system and how the answer to the challenges this posed laid the foundation for a Dutch multidisciplinary consensus-based guideline on spiritual care in palliative care. Finally, the paper also explores how this resulted in the Dutch initiative known as the ‘Taskforce on Spiritual Care in the European Association of Palliative Care’.

Characteristics of the Dutch context

In trying to establish a new role during the modernisation of healthcare in the 1960s and 1970s, healthcare chaplains in the Netherlands organised themselves into a multidenominational professional organisation.⁽²⁾ Prior to this point, Catholic and Protestant clergy had held respected positions in healthcare institutions. In non-denominational settings, local churches offered chaplaincy, and this

service was mostly restricted to the members of these churches. The title or name of the spiritual caregiver's profession and function reflected the denominational preferences.

From the foundation of the Dutch Association of Spiritual Caregivers in Healthcare Institutions (VGVZ)(3) in 1971, healthcare professionals from another influential denomination, the humanistic counsellors, applied and were welcomed as members. The association organised itself in denominational sectors and later also in working fields (hospitals, nursing homes, psychiatry, care of the mentally handicapped, etc.). Although the word 'spiritual' has a central place in the English translation of the profession of 'spiritual caregiver', in Dutch the new organisation did not choose the Dutch term 'spiritueel', but rather the more neutral or broader 'geestelijk'. (In Dutch the words 'spiritueel' and 'geestelijk' are synonyms. Both can be translated in English as *spiritual*. In Dutch 'geestelijk' refers also to the intellectual and mental capacities of a person and 'spiritueel' also refers to the immaterial world.) In fact, the foundation of this multid denominational professional organisation created a new word in Dutch healthcare in order to define 'the professional assistance and guidance to people in fundamental questions of life, sickness and death, given from and based on faith and philosophy of life'.(2) To a certain extent, this definition reflects the period in which the Netherlands seemed to take the lead in secularization in north-west Europe. At that time, the concept of spirituality was probably too associated with traditional belief systems, and insufficiently rooted in the new professional multidisciplinary language in modern Dutch healthcare, to be used without negative traditionalist associations. In search of its identity, the Association was a place of intense debate and this definition of healthcare chaplaincy was eventually amended in 2002 to 'the professional and official guidance of and caregiving to people in the process of seeking meaning for their existence, from and on the basis of religious and existential convictions, and professional consultation in ethical and philosophical aspects of healthcare and management'.(4) Note that even in this definition spirituality

was not explicitly mentioned, although concepts such as ‘seeking meaning’, ‘existence’ and ‘existential convictions’ could be seen as referring to spirituality, as reflected in recent literature.(5)

This linguistically peculiar situation was one of the reasons why spirituality was often neglected or implicitly implemented in psychosocial care. As a result, healthcare chaplains had to establish their role within a bio-psycho-social model of healthcare, without using an important part of their specific expertise: the language of spiritual care. Because of this, the healthcare chaplaincy professionalised and integrated into modern healthcare with a professional profile, handbook and requirements for further professionalization, including clinical pastoral education. This tension led to an ongoing, internal professional debate on how to integrate a multid denominational chaplaincy in healthcare without the loss of its common identity, which was based on its specific expertise and approach. The need for integration was generally felt, but, where the specific approach was at stake, healthcare chaplains often referred to their extraordinary sanctuary function. Healthcare chaplains were not eager to share information about their patients, as they tended to treat all communication with patients as belonging to the secret of the confession. Healthcare chaplains and spiritual caregivers had to interpret and explain their professional activities within the dominant bio-psycho-social model of care.

Consequently, the translation and implementation of the WHO definition of palliative care and its four dimensions, including spirituality, created confusion among healthcare providers and chaplains. In the first place, there was no consensus about what this concept of ‘spirituality’ might mean. Moreover, the concept hardly seemed to be necessary since spiritual care had until then been seen as a specific part of psychosocial care. The first translations of the WHO definition of palliative care reflected this situation by changing the phrase ‘spiritual’ into ‘existential’. And in the first Dutch Master Class on Spirituality and Healthcare Chaplaincy in Palliative Care (2007),(6) chaplains were reluctant to adopt the concept of spiritual-

ity. A fierce, fundamental discussion showed that there were individual preferences for other central concepts (seeking meaning, existential, fundamental life questions), and that there was a fear of being taken less seriously by other professionals and being seen as associated with representatives of trendy, popular or vague spiritual movements. But this discussion did not last long. In the third group of this master class (2008), resistance to the use of the concept of spirituality had disappeared. The awareness that active participation in the development of palliative care in the Netherlands created new opportunities grew rapidly. This active participation contributed to a new multidisciplinary understanding of spiritual care, as described in this paper, which might lead to a renewed integration of healthcare chaplaincy in the Netherlands.

As a result of the prior conceptual and linguistic confusion it was hard to engage in or make use of international discourse and research on spiritual care. Nevertheless, the Dutch National Palliative Care Programme challenged healthcare providers to improve palliative care for all patients in all four dimensions. What were the characteristics of this programme?

Main goals and characteristics of the Dutch Palliative Care Programme

Until the 1990s, palliative care in the Netherlands was hardly stimulated by the government in any national programme. In the public debate about euthanasia, palliative care pioneers acted as the opponents of the practice's regulation. And it was only after this debate was 'settled' – a typically Dutch phenomenon meaning that a discussion is considered to be over and done with – that palliative care could be further developed and stimulated in the healthcare system. At that time most people with severe illness were treated in hospitals and nursing homes. Without explicitly using the modern concept of palliative care, the quality of care in nursing homes had been developed in a comparable way to palliative care (multidisciplinary and patient centred). One of the key factors in this process was the de-

velopment of a new medical specialty, an 'elderly care physician', which at that time was called 'nursing home medicine' in Dutch. Being confronted with the definition and methods of palliative care, the reaction of many nursing home physicians and nurses was one of recognition and familiarity.

In the 1980s and early 1990s, palliative care in the Netherlands was still a pioneer movement, with a few 'nearly-home facilities' and 'high-care' hospices. A national organisation to stimulate and develop palliative care for terminally ill patients in the Netherlands was founded in 1996. In 2009, in a new section of the European Journal of Palliative Care, Arianne Brinkman(7) gives a brief summary of the two-decade development of palliative care in the Netherlands:

at the end of the 1990s the Dutch government began to take an interest in palliative care and started a national programme to stimulate service development and improvement in the quality of palliative care. 'Palliative Care in the Terminal Phase' by ZonMw the Netherlands Organisation for Health Research and Development was the first programme. It focused on promotion of expertise, needs planning and structural change. After that the government initiated centres for the development of palliative care (departments of regional Comprehensive Cancer Centres). The Hospice Care Integration Project group focused on integration of hospice facilities into mainstream healthcare. Based on the results government guidelines were drawn up, which stated that:

- *palliative care should focus on achieving the best possible quality of life for patients, according to the WHO definition,*
- *palliative care should remain, as much as possible, part of mainstream healthcare; general care providers should be supported by, and get advice from, specialised, multidisciplinary consultation teams,*
- *there should be co-operation within palliative care networks to ensure that care is organised as well as possible*
- *there should be support, on a national level, by the Agora Foundation (National Platform for Palliative Care) and by the palliative care departments in the Comprehensive Cancer Centres.*

Palliative care became an important point of focus for government policy at the beginning of the 21st century. Funding for network development, for volunteer coordination and structural financing for palliative units in nursing and care centres became available.

In 2006 the Comprehensive Cancer Centres in the Netherlands published their second practice-based and practice-oriented multidisciplinary guidelines for the practice of palliative care.⁽⁸⁾ In the 768 pages of this book, the word 'spiritual' was only mentioned twice in the index, and referred only to the guideline on existential crisis. This guideline was written from a more psychological perspective, and hardly dealt with the broader practice of spiritual caregivers.

The National Programme for Palliative Care 2008–2010 included three themes: 1) the organisation and financing of palliative care, 2) the improvement of quality of palliative care and transparency, and 3) education and advancement of professionalism. The new government has ordered ZonMw to elaborate a new Improvement Programme, which is to come out in 2012.

Spirituality emerging as a theme: initiatives and choices.

In 2006 both new professors on palliative care in the Netherlands Zuurmond and Vissers articulated the need to integrate spiritual care in clinical practice, research and education.^(9,10) In the same year, the Agora Foundation appeared to be a very strong supporter for the development of spiritual care in the Dutch healthcare system. Its working group on ethics had extended its name to ethics *and* spiritual care, and called attention to the fact that there was an important omission in the 2006 publication of the multidisciplinary guidelines. This group decided to develop a multidisciplinary guideline on spiritual care in order to establish the fourth dimension of palliative care more firmly, and they consequently contacted the editors of the national guidelines. The editors were positive about this initiative and challenged the group to integrate the existing guideline on existential crisis⁽¹¹⁾ into the new guideline on spiritual care.

In the same year, healthcare chaplains who were looking for postgraduate education on spiritual care in palliative care discovered that there was no such course available in the Netherlands. In Rotterdam there was a course in 'Teaching the Teachers' in palliative care, based on an international concept of developing an international community of teachers in palliative care.⁽¹²⁾ This course included a focus on spiritual care within palliative care, and the course's organisers expected healthcare chaplains to engage in its development. During the course, the need was stated for monodisciplinary training for healthcare chaplains on spirituality and palliative care. The internationally experienced educators made a connection between Dutch experts and a German expert⁽¹³⁾ who already had years of experience in mono- and multidisciplinary courses on spiritual care in palliative care in Germany. As a result of these connections, a programme for healthcare chaplains with international and national experts, entitled 'Master class spirituality and chaplaincy in palliative care', was established. Both the Comprehensive Cancer Centre in Groningen and the VGVZ were willing to support this course as a pilot. The response from chaplains all over the Netherlands was overwhelming, and, within a timeframe of three years, 117 chaplains (humanistic, protestant and catholic) had been trained. Compared to the number of members of the VGVZ (about 825), this shows how the initiative served the need to clarify the concept of spiritual care and the position of chaplains in its development.

This master class opened a new view for Dutch healthcare chaplains on the connection between their work and the international debate on spirituality and spiritual care based on the WHO definition. First drafts of the multidisciplinary guideline were discussed in these master classes. It gradually became clear that a guideline on spiritual care should be written primarily for doctors and nurses, and that the commitment of chaplains was needed as experts in this field. During the comment phase of the guidelines, the discussions were intense and vivid. However, after all the reactions had been processed, the editors accepted the final draft, which was published as a consen-

sus-based guideline on spiritual care in the third edition of the practice-based multidisciplinary guidelines for the practice of palliative care in 2010 (for a summary of this guideline, see Appendix 1).(14) In the same year the VGVZ amended the professional definition by introducing the concept of spirituality into their professional standard for healthcare chaplaincy.

Within the same timeframe, the Agora working group on ethics and spiritual care started two other national initiatives that were financially supported by the Dutch government. First, an inventory on expert opinion regarding competencies for spiritual care was created,(15,16) and, second, expert meetings and invitational conferences on the question of how to further develop spiritual care in palliative care in the Netherlands were organised. Both initiatives resulted in publications based on expert opinion and consensus, which were brought to the attention of policymakers by Agora's National Platform for Palliative Care. The last publication has the expressive title *Spiritual care, connecting link in palliative care*.(16)

As a result of these developments, in 2011 the Dutch government mentioned spiritual care as one of the items that will be elaborated upon in a new improvement programme for palliative care.(17)

The actual Dutch situation on spiritual care in palliative care, and its impact on system and practice

Can we say that spirituality is integrated system-wide in the Netherlands Palliative Care National Programme? System-wide integration would be a very pretentious claim. Yet professionals and organisations are making progress with regard to new understandings and practices of spiritual care. An important infrastructure has thus been built in recent years, consisting of:

- a consensus-based multidisciplinary and multidenominational guideline on spiritual care in palliative care;
- an inventory of competencies for spiritual care;

- the introduction of the concept of spirituality in the Dutch professional standard of healthcare chaplaincy;
- a vision on the development of spiritual care; and
- recognition of the importance of spiritual care by the Dutch government.

The acceptance by the editors of the multidisciplinary guidelines for the practice of palliative care of this new guideline on spiritual care is huge. These guidelines are valued by the experts in the multidisciplinary consultation teams throughout the country. The fact that the guideline is consensus based gives caregivers and researchers common ground for practice, education and research. Together with the inventory of competencies of spiritual care, the guideline can contribute to the integration of spirituality in the current national project on competencies for palliative care for all healthcare disciplines. The introduction of spirituality in the professional standard of healthcare chaplaincy expresses the willingness of the majority of healthcare chaplains to contribute to the development of this vital dimension of palliative care.

The EAPC Taskforce Spiritual Care

From the start, members of the Agora working group on ethics and spiritual care oriented themselves on the international debate and research on spirituality. Visiting the congresses of the European Association for Palliative Care (EAPC), they witnessed a significant difference in the quality of presentations and contributions on spirituality in each programme. Scientific and organising committees of these congresses showed interest in this important dimension of palliative care often by inviting national or regional experts. But these contributions lacked a common conceptual basis and were not connected to an ongoing debate. Within the Dutch delegation, the need was felt for a more integrated approach on spirituality within the EAPC. Encouraged by the publication of the Report of the 2009

National Consensus Conference(18) in the United States they wondered: would it be possible to form a platform for exchange of successful training programmes, guidelines, standards, educational projects and research in Europe? Exchange of good practice and development of spiritual care in Europe is not easy because it is integrated in its cultural and linguistic context. Most publications relevant to spiritual care in palliative care are, by their very nature, written in the native language of the primary caregivers.

The Agora Foundation, supported by the Dutch government, organized an invitational conference in October 2010 where 13 participants (doctors, nurses, chaplains, researchers) from eight European countries exchanged and discussed background information on each country and the perception of the field of spirituality in healthcare and its problems.(19) Furthermore, they elaborated a working definition of spirituality (Appendix 2), a mission statement for an EAPC Taskforce on Spiritual Care in Palliative Care, and identified and prioritised four key areas of work: service improvement, strategic planning, research and education. In May 2011 the Taskforce had its first official meeting in Lisbon. A total of 37 congress participants from 14 European countries joined this meeting and formed three working groups: research, education and implementation/recognition. From the outset, the Taskforce had a good balance from a multidisciplinary perspective: twelve primary caregivers (eight doctors and four nurses), thirteen spiritual care providers (catholic and protestant chaplains, humanistic counsellor, philosopher), nine researchers (using various scientific paradigms) and three other professionals (psychologist, social worker, policymaker). The Taskforce has an open character and expects its participants to form or use their own national structures to connect and communicate on a national level. All three international and multidisciplinary groups are coordinated from different European countries: research from the United Kingdom, education from Germany, implementation and recognition from Italy and the steering committee is facilitated by the Agora Foundation in the Netherlands.

By definition EAPC taskforces have a two-year life cycle. At the first meeting participants decided to accept the working definition on spirituality for the next two years, made feasible plans for this first period and welcomed the written invitation to collaborate from the director of the George Washington Institute for Spirituality and Health (GWish), Dr Christina Puchalski. For all three working groups, the first step seemed to require making a map or inventory of successful training programmes, guidelines, standards, educational programmes and research projects. Meetings of the Taskforce will be held at the biannual EAPC congresses and the biannual EAPC scientific congresses. The coordinators of the working groups and the steering committee will have to attract their own funding for attending meetings, translation services and for facilitating this process.

Conclusion

The development of contemporary palliative care within the regular healthcare system in the Netherlands challenged practitioners, researchers and policymakers to reassess the concept of spirituality in palliative care. Within a few years (2007–2011) resistance and scepticism with regard to the necessity and usefulness of the concept gave way to a consensus and willingness to develop the practice of spiritual care.

Key factors in this process were: the existence of an independent national platform on palliative care, where experts could meet and were supported in joint projects; the fact that this process started bottom-up, building on practice-based expert consensus which gradually became confirmed top-down; and the commitment of individuals and other official stakeholders.

The infrastructure is almost finished, and the local practice of spiritual care still varies as before. Key success factors in developing a qualitative multidisciplinary practice of spiritual care seem to be:

- the development, validation and education of practical tools for the primary caregivers in the Dutch context;

- the quality of the input to this process from chaplains as experts, locally as well as in research and implementation (although there are still questions to be solved about e.g. the need for specialized spiritual consultants(20) in palliative care consultation teams);
- the content of the paragraph on spiritual care in the next national programme on palliative care;
- building fruitful cooperation between physicians, nurses and chaplains serving the patients' (and relatives') spiritual needs, based on research methods appropriate to the multidisciplinary and multidimensional concept of spirituality.

In the Netherlands, the creation of the EAPC Taskforce, and the cooperation within this organisation, can be seen as offering promising support for the process of developing multidisciplinary spiritual care in palliative care.

Appendix 1: English summary of Dutch Guideline on Spiritual Care in Palliative Care.

The guideline is primarily written for doctors and nurses, without excluding caregivers of other disciplines, nor volunteers. The guideline offers a practical guide to distinguish between:

- A. situations where ordinary attention for patients life or vital questions in care;
- B. situations where patient need guidance on this or are going through a normal struggle where guidance by an expert can be valuable;
- C. situations where the wrestling with the life or vital questions are leading to an existential crisis that needs crisis intervention by a chaplain, social worker or psychologist.

The position of spirituality is seen as the most intimate and hidden dimension, less measurable than the other three, but continuously in a relation of mutual influence (see Figure 1.).

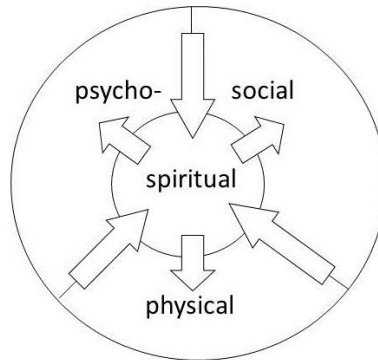


Figure 1 The position of spirituality.

Spirituality is defined as the 'philosophical/life reviewing functioning of man, to which questions of experiencing meaning and giving meaning can be accounted'. Spirituality is related to all possible – from religious to everyday – sources of inspiration. For some people

the accent is on the emotional inner life (e.g. prayer, enjoying nature, literature music, art) or activities (meditation, performing or participating in rituals, or putting effort for a good cause), others experience it more intellectually (contemplation, study). Spirituality influences our entire existence, is dynamic, and has more to do with the source of our attitudes than with a defined area of life.

Spiritual care has three characteristics:

1. attention for this dimension of care is important from the early beginning of the palliative phase, so that questions and expressions in the whole of the spiritual process can be seen / understood;
2. there are always different layers of meaning in language in this dimension of care that interconnect; many expressions of patients or proxies can be understood on different levels:
 - physical level: as an expression with regard to the physical dimension, a verifiable or factual state,
 - psychological level: as an expression of thoughts, images, feelings hidden in the expression,
 - social level: as an expression of the social environment to which the person is connected, expressing a part of his identity,
 - spiritual level: expressing ultimate concerns, inspirations and meaning, often connected with ordinary things in life.
3. it usually concerns questions and expressions to which no solution can be given, demanding presence, attention and commitment.

Development and progress of spiritual processes in palliative care are considered to be similar to development and progress of an existential crisis. Phases can be distinguished as confrontation with approaching end of life, loss of grip, loss of meaning/sense, grief, finding/experiencing, meaning/sense, integration of giving and experiencing meaning/sense. Spiritual distress can be missing. When the spiritual process is blocked it can be seen as an existential crisis. Although it is stressed that spiritual needs should not be treated in a

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problem-oriented approach. Also, positive spiritual needs (as for example celebrating one's life) demand attention and commitment. Primary caregivers have an important role in identifying and opening up spiritual themes and needs. Two kinds of diagnostic instruments are given for screening and history taking. For screening a translation is given of the Mount Vernon Cancer Network spirituality assessment tool(21) with its three cue questions: 1. How do you make sense of what is happening to you? 2. What sources of strength do you look to when life is difficult? 3. Would you find it helpful to talk to someone who could help you explore the issues of spirituality/faith? For history taking, first the FICA and SPIRIT tools are given in English with the comment that both of them are functioning in the North American context. Both instruments are not yet tested or used in Dutch. Additional to them, the Dutch *Ars Moriendi* Model (art of dying) of Leget is given with its central concept of *inner space*.(22)

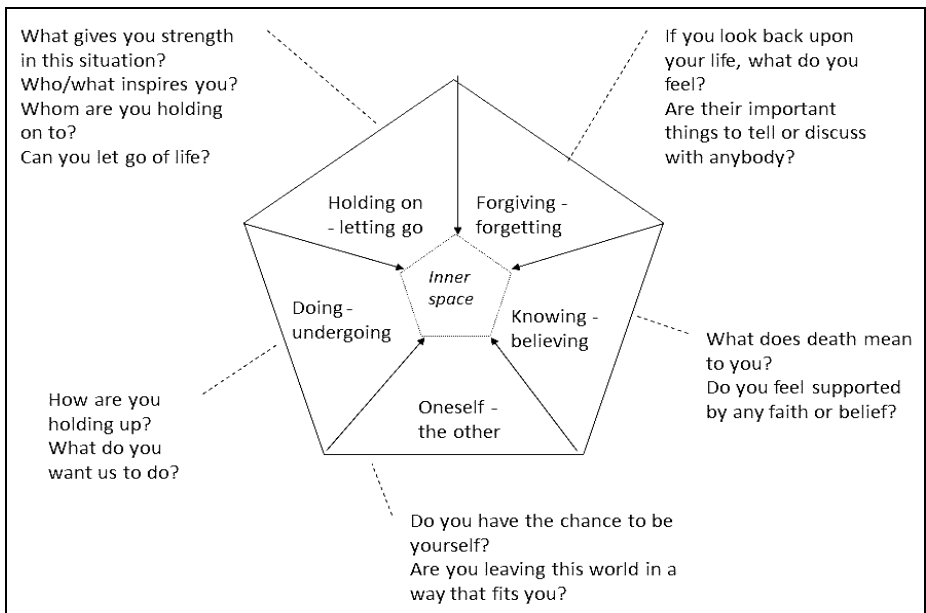


Figure 2 *Ars Moriendi* Model.

The state of mind that enables one to be aware of one's actual thoughts and feelings without being overthrown or swept away by them. Spiritual care is directed to the restoration or enhancement of that inner space of the patient, the family and/or the caregiver. In this model Leget distinguishes between 5 fundamental themes that appear as dynamic tension fields when end of life is near. Themes that can be approached from or within the inner space not as choices (either ... or ...) but as tensions (both ... and ...).

For the treatment of spiritual needs or practice of spiritual care the guideline states that it is by definition a multidisciplinary activity. Cooperation is designated but the various disciplines have their own role and task. Based on the distinction between A. situations that need attention, B. situations that need guidance and C. situations that need crisis intervention the role of different caregivers can be situated as in Table 1 Forms of spiritual care.

		Doctors, nurses	Medical social workers, psychologists	Health care chaplains	
	<i>Primary focus, access and frame of reference</i>	<i>Somatic</i>	<i>Psychosocial</i>	<i>Spiritual</i>	
A	Attention <i>(always)</i>	Listening, supporting, recognizing, screening	Listening, supporting, recognizing, screening	Listening, supporting, recognizing, screening, interpreting	Representing and connecting
B	Counselling <i>(at patient's request)</i>	Following the search process, referring, assessing	Following the search process, referring (->) assessing	Following the search process (<-) referring assessing, interpreting and appraising	
C	Crisis intervention <i>(if indicated)</i>	Detecting, referring	Recognizing, counseling, treating referring (->)	Recognizing, counseling, (sometimes) treating, (<-) referring interpreting and appraising	

Table 1 Forms of spiritual care

Appendix 2: EAPC Working definition 2010 on Spirituality

Between 15 and 17 October in Werkhoven, the Netherlands,(19) thirteen palliative care professionals from various backgrounds and eight countries considered the North American ‘consensus definition of spirituality’ to be an important development. They used it as a foundation and, from a European perspective, felt the need for adjustments:

- The phrase ‘Spirituality is the aspect of humanity’ implies that spirituality is but one more component of being human, rather than that which infuses every aspect of human experience ...
- The phrase ‘the way individuals seek’ reinforces an overly individualistic approach to human spirituality, and glosses over the fact that the individual spirit is born into, and thrives within, a community.
- The phrase ‘seek end express meaning and purpose’ seems to limit spirituality to a concern with meaning-making, and leaves it open to being understood as a purely conscious process, whereas much meaning-making is unconscious.
- ... the importance of including transcendence in any definition of spirituality, on the understanding that transcendence, ..., conveys the sense that human beings experience themselves as more than just physical beings. The term is open to being interpreted as psychological transcendence, and /or as implying transcendence in a more traditionally religious sense.

EAPC definition on spirituality:

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and / or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and / or the sacred.

The spiritual field is multidimensional: 1. Existential challenges (e.g. questions concerning identity, meaning, suffering and death, guilt

and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy). 2. Value based considerations and attitudes (what is most important for each person, such as relations to oneself, family, friends, work, things, nature, art and culture, ethics and morals, and life itself). 3. Religious considerations and foundations (faith, beliefs and practices, the relationship with God or the ultimate).

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